City of Bloomington
Housing & Neighborhood Development ——— **349-3401**
401 N. Morton ——— **349-3420**
P.O. Box 100
Bloomington, IN 47402 **Fax:** **349-3582**

Information Sheet

Social Service Funding Applications for
2005-2006 Community Development Block Grant Program

Applications are due November 19, 2004, by 4:00 p.m. in the Housing & Neighborhood Development Department

Submit the original and 15 copies of the completed application.

General Instructions:

1. All applications must be typed. Font size shall be at least 12 points.

2. Please respond to each section of the application as clearly and concisely as possible.

3. Please confine your responses to the space provided and provide both narrative and quantitative information in describing your organization/agency and the program for which funding is being sought. Do not attach additional sheets**,** except requested financial information.

4. All applications must be received by the due date. **LATE APPLICATIONS WILL NOT BE ACCEPTED.**

Funding Requirements:

1. In accordance with Federal law, to be considered for funding, the agency must have an affirmative action plan, be incorporated, have an accounting system compatible with Federal Regulations, and eliminate any provision or practices that discriminate or has the effect of discriminating. Please turn in your affirmative action plan to the City of Bloomington Human Rights Department prior to October 29, 2004. For assistance, please contact Human Rights at 349-3429.

2. Agencies will need to supply HAND with a copy of the most recent Audit, including the Management Letter, prior to the release of any funding. If you are applying for both Social Service and Physical Improvement funds, you need only supply one copy.

3. Only one application per agency will be accepted.

4. Community Development Block Grant funds must be used to provide services to income eligible City of Bloomington residents only. Please refer to the CDBG Program Guidelines for Determining Eligibility to ensure that your program can adhere to eligibility requirements.

5. Requests for less than $3,000.00 will not be considered. Maximum request considered is $25,000.00.

Application Instructions:

Question 1 – Organization/Agency History and Goals: This question is related to your agency, not the program for which you are requesting funding. Describe your agency, the type of programs your agency administers, the type of clientele provided services under those programs, how long has the agency provided services within the community, and the size of the agency in terms of employees.

Question 2 – Activities: Please briefly describe activities to be completed under this grant. Please be concise and confine your answer to the space provided. Do not use additional space.

Question 3 – Program Need: Your discussion should address how the program serves the needs of the community and its residents, how this need is quantified and documented by citing relevant data (you may use either existing data, any needs assessments which have been conducted such as the SCAN – Service Community Assessment of Needs, the City's consolidated plan, or other sources of documentation as appropriate.) You should also address how the program fits within the needs of the community.

Question 4 – Evaluation Methodology/Outcome Measurement:

Part A.
a. Describe your evaluation tool, including your benchmarks or goals.
b. Tell us about the data you collected using your evaluation tool in 2003.
c. What was the outcome of your data collection – ie satisfaction surveys, client improvement, etc.
d. Did you make any changes to your program based on your evaluation? If so, please describe.

Part B.
Fill out the Outcome Measurement Grid for Fiscal Year 2005-2006. See attached Sample.

Question 5 – Client Data:

Part I. Client History:

1. Please tell us how many clients you served for THIS program between June 1, 2003 and May 31, 2004.
    a. How many were city residents.
    b. How many were CDBG eligible based on the 2003 income guidelines (if you were a CDBG recipient that fiscal year, you should have this information from your monthly status reports).
2. Please tell us how many clients you estimate you will serve for THIS program between June 1, 2004 and May 31, 2005.

a. How many are city residents.
b. How many are CDBG eligible.

3. What is your activity level goal for this year (see current funding agreements, Section I. C. Levels of Accomplishment).

Part II. Proposed Level of Activity:

1. Estimate how many clients you will serve for THIS program 2005-2006 including non-CDBG eligible.
    a. How many do you estimate will be city residents.
    b. How many do you estimate will be CDBG eligible.
    c. Of the City clients, how many do you estimate will be low income based on the supplied chart.
    d. Of the City clients, how many do you estimate will be very low income based on the supplied chart.
    e. Of the City clients, how many do you estimate will be female head of household as defined as a single adult female with dependent children.
2. Tell us how these estimates compare to your last year's actual client counts.
3. Tell us your average per client cost. How much does it cost for you to serve one client.
4. Please tell us how you calculated this amount.

Question 6 – Budget Information: Self-explanatory.

Question 7 – Previous Effort: **NEW PROGRAMS ONLY.** You do not need to answer this question if you have received CDBG funding in the past.

Question 8 – Program Budget: Fill out the budget worksheet showing both your past fiscal year, current fiscal year and proposed fiscal year budgets. Equipment purchases are not an eligible CDBG expense. In the column titled *Amount of CDBG funds per line item*, please tell us how much you expect CDBG to pay of each line item.

Question 9 – List all sources of income . . . : Please list all of the sources of income you have for THIS program for the fiscal years designated.

Question 10 – List other grants . . . : Please list all of the funds your agency will apply for that will contribute to the cost of running THIS program.

Question 11 – List any fundraising . . . : Please list all fundraising activities for THIS program. You may also want to include fundraising activities that are very well known that are used for other programs and explain.

Question 12 – List any current fundraising . . . : Please list any current or future fundraising activities your agency is/will be undertaking for THIS program.

Question 13 – List all staff . . . : Please list all staff for THIS program by title, not name. Please indicate full time (FT) or part time (PT), how many hours per week is charged to this program by this staff member, the amount of salary charged to this program for those hours, and whether or not any portion of this will be covered by CDBG funds.

CDBG Program Guidelines for Determining Eligibility

Eligible social service programs must be run by a 501(c)3 organization or a governmental entity. The following outlines the documentation and reporting requirements:

If the program provides emergency **food** provisions/services ***and*** is located in a qualified census block group **or** if the program/service is located in a public housing authority facility:

1. Provide an unduplicated count of clients served who are city residents by race.
    a) If you are a direct services provider, clients will need to fill out the attached direct service provider race form. Please also provide information on Female Head of Household defined as adult female with no male significant other ***with*** dependents.
    b) If you serve other agencies, each agency located in the city limits must provide unduplicated client count by race and Female Head of Household.
    c) If your per unit reimbursement is not based on number of people served, information on clients must be provided at least bi-annually (or when ½ the funding is expended and when the entire amount of funding has been expended).

If your program does not fit the above described category:

1. Provide an unduplicated count of clients who are city residents broken down by:
    a) Race (see attached information on racial categories).
    b) Female Head of Household defined as adult female with no male significant other ***with*** dependents.
    c) Income at or below 30% area median income; between 30-50% area median income; and between 50-80% area median income. See attached income guidelines. Acceptable income documentation is as follows:
        i. Address of public housing (i.e. Crestmont)
        ii. Letter verifying Section 8 assistance from BHA
        iii. Copy of TANF card
        iv. Copy of one month's worth of pay check stubs
        v. Copy of Social Security Benefit Amount letter or Social Security Verification form (see attached)
        vi. Employment Verification form (see attached)
        vii. Copies of ***signed*** federal or state tax forms or print out from IRS or Department of Revenue regarding last year's tax forms
        viii. Copies of W2's
    d) Client Profile reports must be filed monthly with claims.

Verification of Social Security Beneifts

The person identified below has requested assistance through _____. The individual has authorized your release of the requested information. The information you provide will be used only for the purpose of determining the family's eligibility for this program. We are required to complete our verification process in a short time period and would appreciate your prompt response. A self-addressed envelope has been included for your convenience. If you have any questions, please feel free to contact _____, at _____. Thank you.

Part I. Applicant Information (To be completed by applicant)

Name of Applicant: _____

SSN:_____

Address of Applicant: _____

_____

Part II. Social Security Data (To be completed by Agency)

Client Name: _____ Date of Birth: _____

Monthly Payments from this Agency:

Gross Monthly $_____

Supplemental Security Income $_____

Other (Specify) _____ $_____

_____ $_____

Total Amount Received Monthly: $_____

Start Date: _____

Closing Date: _____

Do you expect any change in payments in the near future? o Yes o No

If yes, please explain.

Additional Comments: (e.g., any special situations, etc.)

Completed by: Name: _____

Title: _____

Signature: _____

Date: _____

Tele. No.: _____

Warning: Section 1001 of Title 18 of the U.S. Code makes it a criminal offense to make willful false statements or misrepresentations to any Department or Agency of the United States as to any matter within its jurisdiction.

Verification of Employment

The person identified below has requested assistance through _____. The individual has authorized your release of the requested information. The information you provide will be used only for the purpose of determining the family's eligibility for this program. We are required to complete our verification process in a short time period and would appreciate your prompt response. A self-addressed envelope has been included for your convenience. If you have any questions, please feel free to contact _____, at _____. Thank you.

Part I. Applicant Information (To be completed by applicant)

Name of Applicant _____

Address of Applicant _____

_____

Part II. Employer Information (To be completed by applicant)

Name of Employer _____

Address of Employer _____

_____

Part III. Employment Information (To be completed by employer)

1. Date of Employment: _____ Position/Occupation: _____
2. Date of Termination (if applicable): _____
3. Current Rate of Regular Pay $_____ per _____ (hour, week, month, year, etc.)
4. Current Rate of Overtime Pay $_____ per _____ (hour, week, month, year, etc.)
5. Do you anticipate any change in the employee rate of pay in the near future?
   o Yes o No. If yes: Revised Rate _____ Effective Date _____
6. Number of hours/weeks employee normally works _____
7. Do you anticipate any change in the number of hours the employee works: o Yes o No
   If yes, explain under #14 below.
8. Anticipated average amount of overtime/week _____
9. Gross **annual** earnings you anticipate for this employee for the next twelve months.
   (Gross amount including all tips, bonuses, overtime, commissions) $_____
10. Does this employee receive vacation with pay? o Yes o No
11. Does this employee receive sick leave pay? o Yes o No
12. If the employee's work is seasonal or sporadic, indicate lay-off periods: _____
13. Does this employee receive an earned income tax credit? o Yes o No
14. Additional Comments:_____

_____

Completed by:

Name: _____

Title: _____

Signature: _____

Date: _____

Tele. No.: _____

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Sample

Community Development Block Grant Application
Outcome Measurements Grid

Problem, Need, Situation	Service or Activity	Benchmarks		Outcomes		Measurement Reporting Tools/Evaluation Process
		Output Goal	**Output Results**	**Achievement Outcome Goal**	**End Results**	
Short-term Goals:						
Low-income individuals and families need down payment and closing cost assistance to help them purchase homes.	Down Payment and Closing Cost Assistance Program which provides $3,000 grants to eligible individuals/families.	12 grants provided.		12 individuals/families will receive grants and will be more satisfied with their living arrangements.		Follow up surveys with clients to determine satisfaction level of housing arrangements and financial situation.
Long-term Goals:						
Improve individuals and families long-term financial picture by stabilizing their housing arrangements.	Same activity as above.	12 grants provided.		90% of those who receive down payment and closing cost assistance will maintain their housing for a period of 5 years.		Forgiveness of recorded Mortgages will allow HAND to track turn-over rate for at least 5 years.